Report to the
North Carolina General Assembly
2005 Session
On
NC Health Choice for Children

History of the Program

In 1997 the United States Congress created Title XXI of the Social Security Act to address the problem of the growing number of children without health insurance in the United States. The Children's Health Insurance Program (SCHIP) was the largest health insurance initiative since the creation of Medicaid (Title XIX) 30 years earlier. Title XXI, established in federal law under the Balanced Budget Act of 1997, offered a block grant to states enabling them to design state specific programs to provide health insurance to uninsured children from birth to 18. Congress decided that the program would not be available to those eligible for Medicaid nor for those with existing comprehensive health insurance. The program could be provided for children up to 200% of federal poverty level or a higher federal poverty level if the state chose to do so.

The stated purpose of the program is to provide health insurance for the children of the working families of the nation and by so doing increase health care access for all children.

Early in 1997 at the request of the State Secretary of Health and Human Services, the NC Institute of Medicine established a Task Force to examine the best way to provide health insurance for uninsured children in North Carolina. This was done in preparation for the implementation of SCHIP. After months of deliberation, the Task Force offered two choices to provide the care: through Medicaid or through the State Employees Health Plan.

An ad hoc committee of the NC General Assembly began examining the Task Force proposals to determine the most effective way of providing services to North Carolina children. The committee established certain basic principles:

1) Children up to 200% of the federal poverty level should be covered.
2) The program should be a stand alone program in part to ensure that children of state employees would be eligible since no state money pays for dependent children's benefits under NC Teachers and State Employees Comprehensive Major Medical Plan.
3) That copayments should be minimal.
4) That the range of benefits should be as broad reaching as possible.
5) That the existing infrastructure should be used in all available cases to keep administrative costs to an absolute minimum.

With these principles as a guide, a special session of the NC General Assembly was called by the Governor. The sole purpose was to consider a children's health insurance plan. The Administration recommended:

1) A Medicaid look-alike program ,using the existing Medicaid infrastructure to determine eligibility up to 200% of the federal poverty level and the Medicaid infrastructure to pay claims; and
2) The use of Division of Public Health social marketing tools to conduct outreach activities; and

3) Copayments of $3 for non preventive physician office visits, $3 for brand name drugs, $5 for outpatient hospital visits and $20 for non emergency emergency-room visits.

The Senate passed the bill proposed by the Administration on the first day of the special session.

When the Senate bill reached the House, a new proposal had been created. The House proposal called for:

1) Benefits to be tied to the State Employees Health Plan,
2) Eligibility offered at 185% of the federal poverty level,
3) Higher co-payments,
4) A waiting period of six-months without comprehensive medical insurance, ,
5) Monthly premiums above 133% of federal poverty of 134-150--$5 per child, maximum of $15 per month; 151- 185--$10 per month, maximum of $28 dollars per month, and
6) Co-payments of $5 for office visits, $6 for prescription drugs and $20 for non-emergency emergency-room use

At the end of six weeks, a compromise had been reached. In the compromise, the State Health Plan benefits would be used for the core benefits, but there would also be wrap around benefits to the Medicaid level for children with special needs. In addition vision, dental and hearing benefits would be added to the core plan. Outreach, eligibility, special needs and overall administration of the program would remain in DHHS but benefits would be paid through the State Employees Health Plan. The waiting period during which a child would have to be uninsured would be six months for the first six months of the plan, then dropped to two months. Monthly premiums were dropped from the House plan and the House level copayments accepted.

The federal government approved North Carolina's plan on July 14, 1998. The program opened on October 1, 1998, and was named NC Health Choice for Children after consultation with focus groups. By the end of the December 1998 there were 17,887 children enrolled in the program.

During the first two years of NC Health Choice, the primary focus was on outreach, ease of enrollment and removal of stumbling blocks to enroll in the program. The application form was reduced to a one-page front and back form that was to be used to apply for children's health insurance whether it was Medicaid children's health insurance or NC Health Choice. This was later modified as a result of focus group discussions to a yet more reader friendly form featuring more white space and less ambiguous questions. That form is now two front and back pages.

As the program matured, the need for changes to the program became obvious. To date, there have been seven amendments to the original legislation. Each amendment resulted either from legislation passed by the NC General Assembly or a federal mandate. Now incorporated as part of North Carolina's NC Health Choice plan, these amendments are:

1. To redefine insurance so that Medicaid was removed from consideration as insurance, thus enabling a child to go directly from Medicaid to NCHC without a waiting period.
2. To redefine clinic to include school based health centers.
3. To add fluoride applications twice during a 12-month period, sealants, therapeutic pulpotomies, and prefabricated stainless steel crowns to the dental benefit
4. a. To conform state and federal law so that Native Americans who are members of federally recognized tribes pay no out-of-pocket costs, and
   b. To assure that children with special health care needs are not required to meet a period of having no insurance before enrollment.
5. To redefine eligibility so that the state can impose a freeze and a waiting list.
6. To eliminate the required period of time for having no insurance before enrollment for all children.

   (*Note: This amendment required that the impact of this change be "tracked." From February 2002 when this provision first went into effect until July 2004 a total of 123 families had dropped insurance to avail themselves of this provision. During that same period of time well over 50,000 families had enrolled in the program.)*
7. To change the co-payments for those below 150% of the federal poverty level from no copayment for prescription drugs to $1 for generic, $1 for brand with no generic available and $3 for a brand with a generic available. For those above 150% federal poverty level, drug co-payments were changed from $6 for all prescription drugs to $1, $1 and $10. This represented the first time that co-payments were paid by those below 150% of federal poverty level. The other co-payments for those above 150% federal poverty level remained at $5 for an office visit to a provider or clinic and $20 for a non-emergency emergency room visit.

The original 1997 Balanced Budget Act (BBA) which created Title XXI included a ten-year budget projection. Normally, national program budgets are established for five years in federal law. Title XXI will be eligible for reauthorization in 2007. Some efforts to reauthorize may well begin earlier. Across the country, the SCHIP program is very popular especially as the economic picture darkened for many families during the recent economic downturn. Some states have taken their eligibility ceiling over 300% of the federal poverty level, while still others have left theirs at 185%. New federal waivers have made it possible to cover unborn children and parents of SCHIP children. Some states have been able to add waivers to cover childless adults below 200% of the federal poverty level as well.

It is widely believed that the debate over reauthorization will center on the formula by which federal funds are distributed. The method of distribution has been cited as the primary reason many states have either run short of money or left large amounts of federal dollars lying on the table. The impact of the funding formula on North Carolina (the state has worked hard and successfully to maximize the federal dollars available to it) is that North Carolina has faced consistent underestimates of its uninsured children

and has had difficultly knowing how much state money to make available to draw down federal dollars. Here is how the funding formula currently works.

Each year the federal government estimates how many uninsured children each state has. The estimates have been variable, putting some states like North Carolina at risk of having insufficient funds to cover all children, while other states have far more money than they need. Although the federal financial participation varies slightly from year to year, generally the federal government contributes approximately 75 percent to the North Carolina program and the state General Fund contributes 25 percent.

When SCHIP was created in 1997, $40 billion was allocated to the program for a ten year period. For FFY2005 and FFY2006, the annual national amount allocated to SCHIP is $4.05 billion; for FFY2007 that amount will increase to $5 billion.

There are two components in contention in the funding formula. The first is the cost formula. The "cost factor" is a reflection of a state's wages relative to the national average. In other words, those states that have a low average wage will have a slightly smaller allocation, while those with a higher average wage will have a slightly larger allocation. This was done in order to reflect the different cost of living in different states.

The second is the number of children. The funding formula changed over time by combining two components—the number of uninsured low-income kids, and the number of low income kids. Low income is defined as those children in families earning less than 200% FPL. In the first three years of the program, uninsured low-income kids was the sole factor. In 2001, the numerical basis of a state's allocation was 75% uninsured low-income kids, 25% low-income kids. Since 2002, 50% of each has been the standard.

The number of kids in each category is obtained from the March supplement to the Current Population Survey and averaged with the same data from the previous two years (for a total of a three year average) in order to minimize substantial fluctuations.

After funding for territories is skimmed off the top of the national allocation, the remaining amount is allocated to a state according to a specific formula. To keep the formula comprehensible, "number of kids" is a composite number comprised of 50% uninsured low-income kids and 50% of low-income kids.

[(Number of kids in a state) X (state cost factor)] ÷ Number of kids nationally

This formula produces a percent. The state then receives that percent of the national allocation.

Because the formula is based on a defined federal allocation, federal funding does not reflect a "cost per child" calculation. If the number of uninsured children goes up nationally, the aggregate amount available for SCHIP does not also increase. The only way a state can receive additional funds for eligible children is if their population of low

income and uninsured kids increases as a percent of the national population of low income insured and uninsured kids.

Each year since FFY1997 each state has received a federal allocation that must be spent within three years. If the funds are not spent within three years, the excess must be returned to the U.S. Treasury and redistributed to those states that have exhausted their allocation. These reallocated funds are additional sources of revenue for programs and North Carolina has benefited from these reallocations.

Here is the state's history on reallocated federal dollars. North Carolina used all of its 1997 and 1998 dollars. Part of the 1999 allocation had to be returned to the federal government because the reallocated dollars from 1997 and 1998 pumped money into the program at a point in time when it could not be spent within the six months allotted (later that money was returned again to the state and completely used). The state spent all of the 2000, 2001 and 2002 allocation and has already begun to spend the 2003 allocation. There are three more allocations already established in federal law before the program will have to be reauthorized. President Bush has said more than once that he will ask Congress to reauthorize the program in 2005. The allocation formula will be a focus of any reauthorization discussion.

Nationally many states have the opposite problem to North Carolina. In those states the estimated number of uninsured children is far greater than the number that actually exist. Many of these states have waivers permitting them to creatively use their funds to address a broad array of issues surrounding those who are uninsured. As a result, 10 states offer family coverage in order to cover uninsured parents. Two states offer their SCHIP programs to childless adults as well.

How North Carolina's Program Stacks Up to the Rest of the Nation

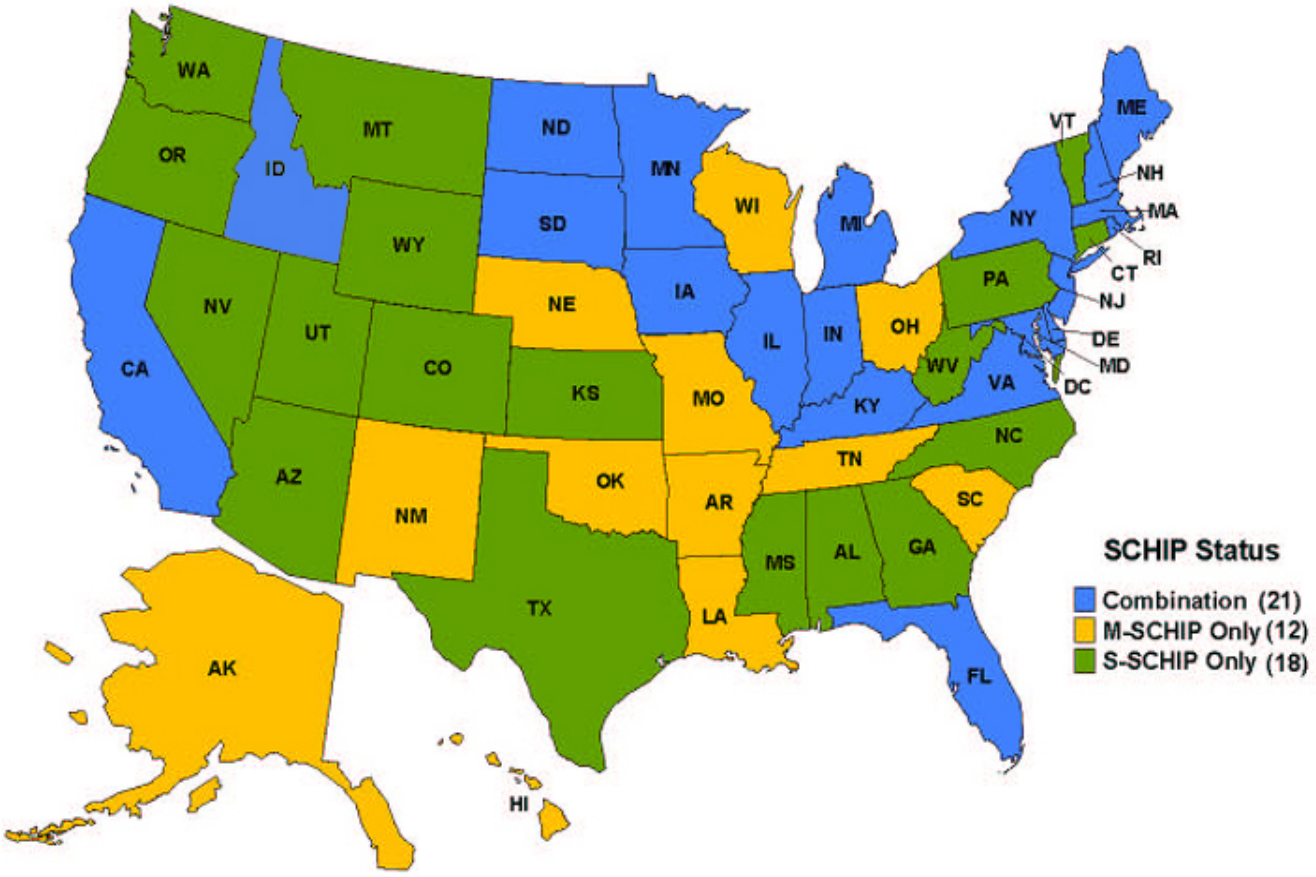
There are 56 Title XXI programs in the states and territories of the United States. There are three different ways that states can structure their SCHIP programs:

1) A stand-alone program,
2) A Medicaid expansion or
3) A combination of both of these programs.

Of the 56 programs, 18 are "stand alone" programs, 12 are Medicaid expansion programs and 21 are combination states.

SCHIP Program Type

Updated: 9/04



Within stand-alone programs, a state could design a Medicaid-like program (meaning, one with benefits benchmarked in the Medicaid program, but with no entitlement). States also have the option of benchmarking their SCHIP program in the health insurance programs of state employees, federal employees or the largest HMO in the state. In the case of North Carolina, we have a stand alone program. North Carolina's NC Health Choice program is categorized as "secretary approved coverage" because this program is referred to nationally as a "core-plan plus". The core plan of NC Health Choice is the NC Teachers and State Employees Comprehensive Major Medical Plan. In addition the NC General Assembly added a special needs wrap around package to the Medicaid level, and vision, dental and hearing programs with legislatively specified benefits coverage.

Using the 2003 survey of the nation's SCHIP programs by the National Conference of State Legislatures, North Carolina's program compares to other states as follows:

- On eligibility levels North Carolina is one of 27 states covering children under SCHIP at 200% of the federal poverty level. There are 12 states that cover children over 200% of the federal poverty level.
- On optional benefits and services in non-Medicaid SCHIP plans, North Carolina covered all but three—over the counter medications (covered by 21 states), prenatal care (covered by 35 states), and interpreter services (covered by 24 states).

North Carolina's program covers dental, vision and hearing services. Each of these services is unique to NC Health Choice for Children. Described benefit by benefit by the General Assembly, the details of governing policy have been developed as a combination of Medicaid and State Health Plan benefits. For example, eye exams are permitted annually, eyeglasses and contacts are covered annually. In the area of hearing, hearing tests and hearing aids are covered. There was no experience with these services under the State Employees Health Plan, so Medicaid benefits and expertise were very carefully adapted for use in NC Health Choice for Children.

Under dentistry, North Carolina covers preventive services, sealants, x-rays, fillings, simple extractions, and pulpotomies. It does not cover orthodontics unless medically necessary such as the result of injury or to correct a birth defect such as cleft-lip, cleft palate. Only one state, Delaware, does not cover any dental benefits. Only one state, Illinois, does not specify its dental limits but mirrors Medicaid coverage. Texas covers only emergency services, traumatic damage, cyst removal and orthodontics for certain specified conditions. Under orthodontics five states cover no orthodontics. Five states cover only space maintainers as a preventive service; the remainder cover some degree of orthodontics when medically necessary or with dollar limitations.

Special Therapies

States approach mental health services differently as well. Arkansas and Wyoming do not cover any inpatient mental health benefits. North Carolina is one of six states requiring prior authorization or medical necessity determination before inpatient coverage is allowed. The remainder established a day-per-year limitation. On outpatient

coverage, North Carolina allows 26 visits without prior authorization. Following 26 visits, prior approval must be acquired. Seven states have established a set number of visits for each year. For most states, including North Carolina, substance abuse limits are the same as mental health benefits.

Regarding other selected special health care needs benefits, North Carolina covers occupational therapy, physical therapy and speech therapy, supplies and durable medical equipment, home health services to 60 visits a year, private duty nurse care, and case management with prior approval. One state, Arkansas, does not cover occupational therapy or physical therapy. All states cover speech therapy; the remainder cover occupational and physical therapy with some limits. Regarding supplies and durable medical equipment, Colorado covers no supplies. Montana covers no durable medical equipment. Montana also covers no home health services. The rest of the states do cover home health services to some degree. Case management is not covered in Arkansas, Connecticut, Florida, Georgia, Indiana, Massachusetts, Mississippi, Montana, New York, or Pennsylvania. Nursing care services are not covered in Colorado, Iowa, Montana, New York or Pennsylvania.

Funding for NC Health Choice

Because NC Health Choice for Children is not an entitlement, enrollment is limited to the number who can be enrolled within available federal and state dollars. Although the federal financial participation formula has sometimes been debated by the states, North Carolina's 73.79% (2003) ranks 20th from the top in the nation. Mississippi is the highest ranked at 83.63% and 16 states tied for the lowest ffp at 65%. Meanwhile, North Carolina's $81.13 million federal allotment (2002) is the 11th highest in the country. California is highest at $528.47 million while Northern Mariana Islands is lowest at $0.36 million.

The flow of federal funds for SCHIP is complicated. Each allocation can be retained by the state for three years. At the end of that three-year period, any remaining funds are to be reallocated among the states that ran over their earlier allocation.

Funding Example 1999

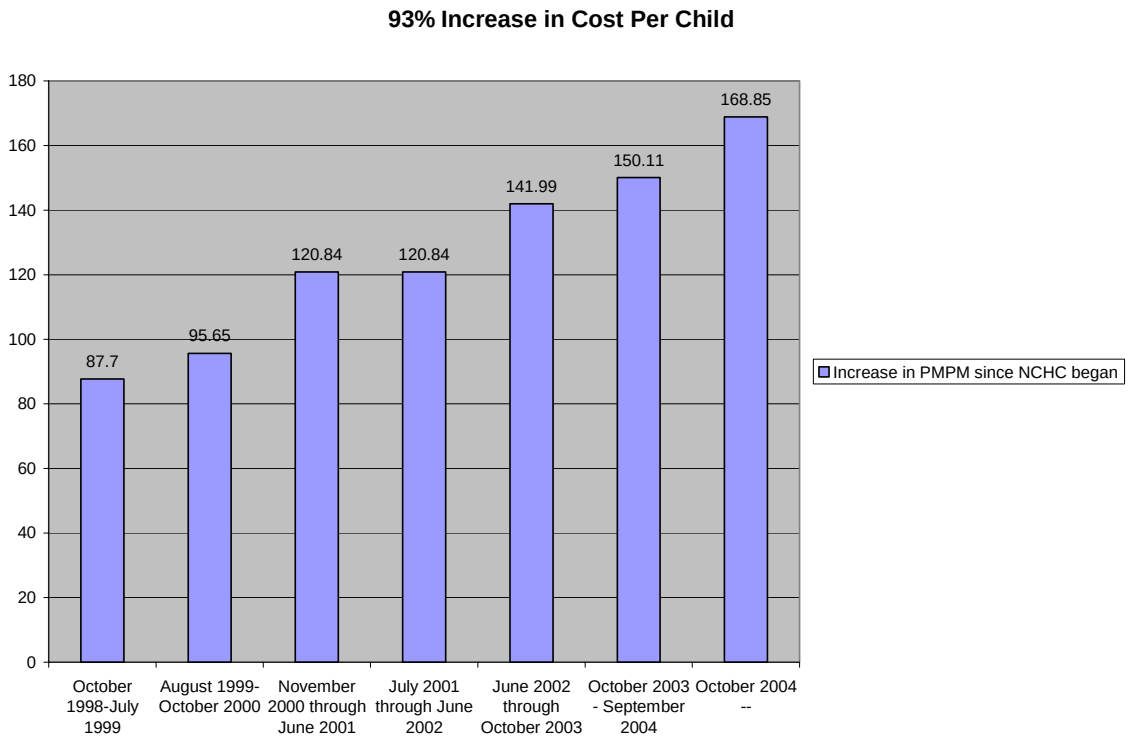
North Carolina's federal allotment for 1999 was $79.13 million. The expenditures against the 1999 allotment were $79.13 million equaling all of the allocated amount. In addition to the $79.13, the state spent out funds that had been redistributed from 1998. Therefore, from 1999 to 2001 the state received a total federal allocation of $171.28—original allocations plus redistributed funds. The amount redistributed from FFY1999 was $92.15 million or the amount over the 1999 allocation that the state spent from the total amount available (all the years of funds allocation combined). Unfortunately, federal reallocations are somewhat difficult to project. Therefore, it is also difficult to request allocations from the General Assembly in order to draw down the federal funds. The $92.15 million was originally reallocated to the state in 2002 with only 6 months left to spend it. Both the original allocation and the reallocated amount were associated with the

year NC Health Choice was frozen because of a lack of state funds to draw down federal resources. Later complaints from states about the reallocations in 2001 led Congress to revisit the 1999 reallocations and re-reallocate them to the states in 2003. When the $92.15 million was returned to North Carolina, the state used all the funds.

Each year states must tell the federal government which year's allocation or reallocation they will spend first. In North Carolina, careful attention has been paid to the order of the funds draw down in order to assure that the state can maximize the federal allocation. Because of the careful selection of the order of the allocation, the state has managed to maximize federal expenditures.

NC Health Choice for Children is now permitted to manage its funding flow at the discretion of the Secretary of the Department of Human Resources. The Secretary can transfer funds in order to draw down new federal dollars. This has made a major difference in the State's ability to manage the program. The inability of the Secretary to transfer funds was the primary reason for the freeze in 2001. The state's matching power was short $1 million in that year.

Funding needs for the program are determined by the number of children enrolled and the actuarially determined per member per month (pmpm) rate charged by the State Employees' Health Plan. The Plan's pmpm charge is based on calculations made by Aon, Inc., the plan's actuarial contractor. Aon's projections for the program's pmpm have been consistent with national trends in the growth of health care expenditures which has been averaging about 12% annually over the last five years.



The transfer of funds works as follows. The State Employees Health Plan retains $3.5 million as a reserve. The Division of Medical Assistance requests funds from the federal government. At each month's billing period, DMA transfers the funds to SEHP. At the end of each month, if the reserve is short, DMA adds more to the transfer to the State Employees Health Plan. If the reserve is over, fewer funds are transferred to SEHP. Net disbursement reports and weekly payout reports are provided by Blue Cross Blue Shield of North Carolina and the State Employees Health Plan so that expenditures can be monitored and accurately predicted for budget needs.

Outreach

NC Health Choice has been particularly successful in its outreach program. The purpose of outreach is to find and enroll children who are eligible for the program and thereby reduce the number of children who are uninsured.

Since the beginning of the program, the outreach efforts have been focused on being family friendly and to combine outreach for NC Health Choice and outreach to enroll children in Medicaid. The family income determines into which program the child is enrolled. Required verification for the program includes wage stubs of all working household members for the preceding month or business records for the self-employed. Should the family income fall between 150% fpl and 200% fpl, the family will also be asked to pay an annual enrollment fee of $50 for one child or $100 for two or more children. Should family income fall below 200% fpl, all of the children below 18 in the family are eligible for health insurance through either NC Health Choice or Medicaid.

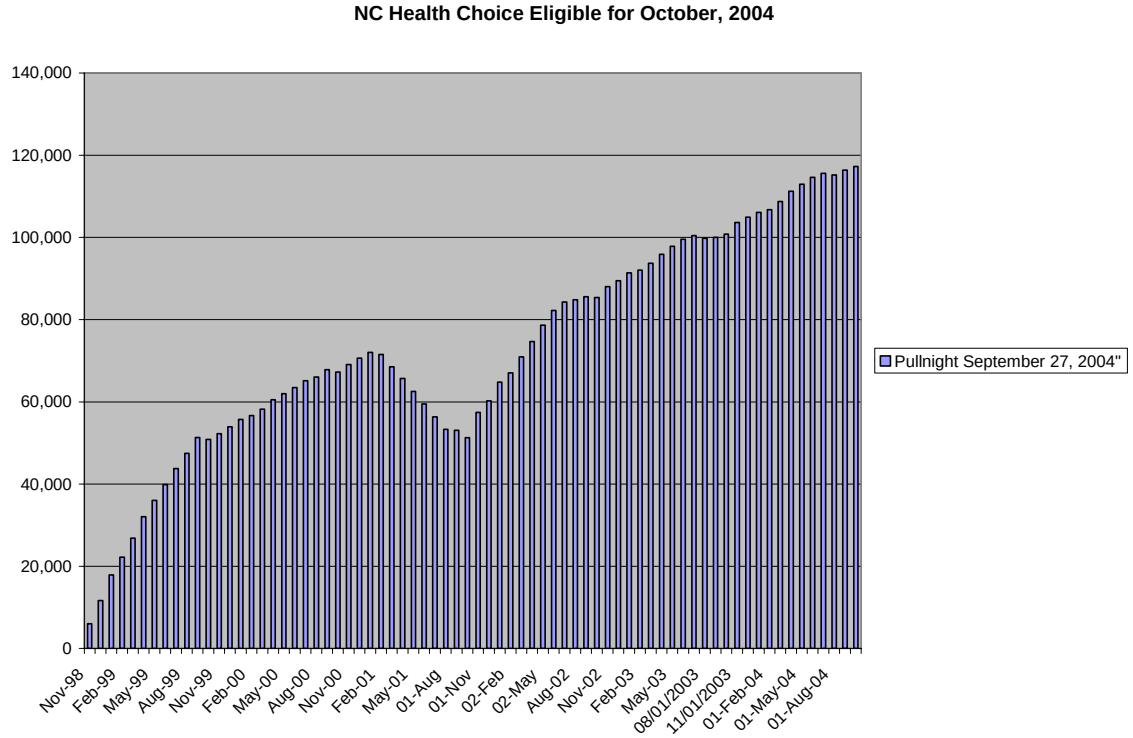
Outreach efforts now focus on assisting families to understand how to best use the health care system. With no ability within the benefits structure of the State Employees Health Plan to require families to use a primary care case management system such as the one employed in Medicaid, outreach has taken a different approach. Efforts are now underway to "sell" the idea of a medical home to the families. That is, requesting each family to choose a doctor to call for their health questions and serve as their primary physician. The goal of this effort is to reduce costs of operation in order to have more funds to enroll more children. Included in this outreach effort are informational cards in English and Spanish describing appropriate actions for the most common non-emergency uses of emergency rooms: ear infections, fever, sore throat. Similar efforts will occur in the future. In addition, emphasis is placed on reenrollment and recruitment of minority populations, including African American, Native American, Latino/Hispanic, and Hmong. Homeless populations are also targets of recruitment efforts.

North Carolina's outreach effort from the very beginning has been one of the best in the nation. In keeping with the overall program goal of keeping administrative costs to an absolute minimum, the outreach program in North Carolina is based on a network of local coalitions made up of volunteers. There is one in each county. Coalitions are made up of citizens in each county who are interested in children's health and well being.

Schools, daycares, businesses, churches, health related groups, community groups and local industries have all participated at some time or another in helping to design ways to make it easier for all the families in the county who may need the program to sign up for it. For the first few years, each county was given a target quota of children estimated to be uninsured in their county. As enrollment grew, it became clear that across the state there were more uninsured children than anyone had estimated.

Like all other states, North Carolina relied on the U.S. Census Bureau's Current Population Survey (CPS) to estimate how many children might be uninsured in the state. The CPS number was also the one used by the Centers for Medicare and Medicaid in determining state allocation levels. In North Carolina the CPS actually showed fewer children living below 200% of the federal poverty level than were enrolled in Medicaid. Clearly the number was wrong, but there was nothing to replace it except past history and guess work. Recently a new effort has begun that should provide the state with more accurate numbers on which to base its budget and to utilize in talks with Congress during the scheduled 2007 reauthorization discussions.

Since the freeze of 2001, additional freezes or caps have been planned for NC Health Choice four times, but in each of those cases, the General Assembly stepped in and either added funding, or as of 2003, permitted the Secretary the same budget authority as she has with other programs to transfer funds into the program to avoid a freeze. Here is the most recent chart of the program's growth history. Please note the eight month dip in enrollment from the freeze. The general trajectory of the program growth appears to have stabilized to one percent per month at the end of calendar year 2004.



Covering Kids and Families

One of the most significant partnerships in NC Health Choice has been the outreach efforts of the Robert Wood Johnson Foundation's Covering Kids and Families Grant. The state is now in a Phase II grant. During the Phase I grant, the RWJ grantee was the Rural Health Initiatives Foundation. In phase I, individual counties were selected to act as idea incubators to test such things as how to:

- Involve physicians and businesses in outreach activities with patients and employees;
- Modify the application form to make it as family friendly as possible; and
- Reach out to minority communities.

Many of the ideas were very successful and adopted statewide, most notably the new and improved application form. Now in Phase II, the RWJ grantee is the NC Pediatric Society Foundation. The phase II activities include research on such issues as outstationing DSS workers and population churning, the development of materials for targeted constituencies and information distribution to networks such as child care providers, medical practice office managers, and others.

The effectiveness of North Carolina's incubator program was so clear and cost effective that it has now become the standard for the RWJ grantees across the country. These private grants have made innovation and experimentation affordable and relatively risk-free. Guidance, consultation and professional support has also been afforded by RWJ for the program. It has made an invaluable contribution to our state.

Who is eligible for N.C. Health Choice for Children?

Eligibility is determined by family income--children must be a part of a family which makes less than the following federal income standard:

200% federal poverty level as of April 1, 2004

Family Size	Annual Income	Monthly Income
1	$18,620	$1,552
2	$24,980	$2,082
3	$31,340	$2,612
4	$37,700	$3,142
5	$44,060	$3,672
6	$50,420	$4,202
7	$56,780	$4,732
8	$63,140	$5,262

150% federal poverty level as of April 1, 2004

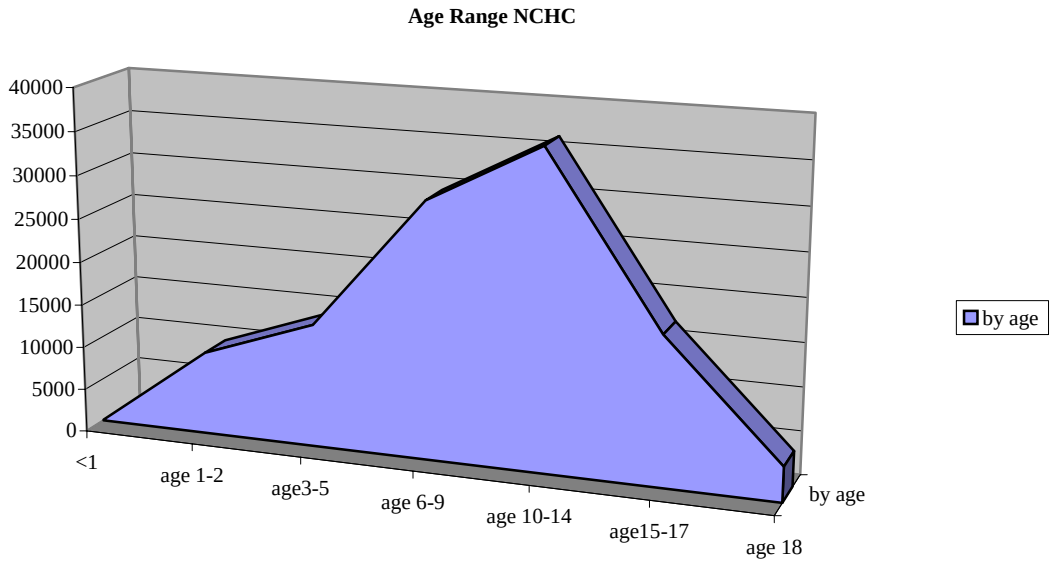
Family Size	Annual Income	Monthly Income
1	$13,965	$1,164
2	$18,735	$1,562
3	$23,505	$1,959
4	$28,275	$2,357
5	$33,045	$2,754
6	$37,815	$3,152
7	$42,585	$3,549
8	$47,355	$3,947

Eligibility determination is based on the preceding one-month's family income.

There are deductions for necessary child care. The amounts are $200 per month per child for children under age 2 and $175 per month per child for children two and over. These amounts are the total amounts that can be deducted per child from the family's earned income. (In other words you cannot deduct $200 from one parent and $200 from the other parent for the same child.)

There is a $90 work-related expense deduction. It is for each family member who works.

Who is enrolled in NC Health Choice for Children?



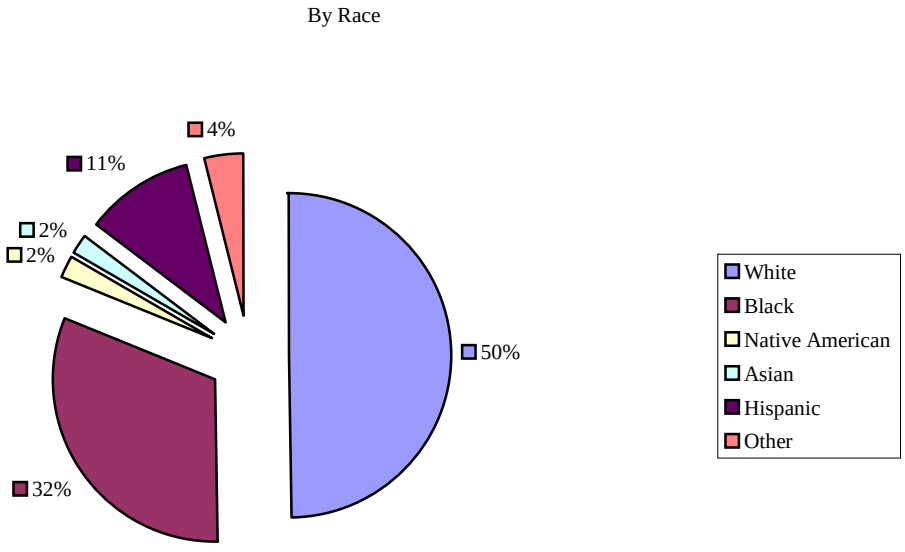
NC Health Choice is layered on top of Medicaid, meaning that eligibility begins where Medicaid ends. Therefore, most of the children in NC Health Choice are school aged. The income levels for Medicaid are as follows:

- Infants to age one are covered by Medicaid to 185% of the federal poverty level. The ceiling of NC Health Choice is 200% fpl. Therefore, there are few infants in the program.
- Preschoolers through their fifth birthday are covered under Medicaid to 133%. Age one to five is covered under NC Health Choice from 133% to 200% fpl, so approximately 20% of NC Health Choice members are in early childhood.
- At age 6, Medicaid eligibility drops to 100% of the federal poverty level. These children are also covered to 200% of the federal poverty level under NCHC. Therefore, 80% of the children in NC Health Choice are school-aged.

About 86% of the children in North Carolina Health Choice came to the program directly from Medicaid and nearly 80 percent fall below 150% of the federal poverty level. The economic mix of families is very similar across the nation. Even states that have raised the upper income level to 300% of the federal poverty level report that the higher the family income the less likely children are to enroll in the program.

The two leading reasons for denial in the program are income above 200% fpl and "already has health insurance." The third highest reason for failure to enroll in the program is failure to pay an enrollment fee. Only 20% of the eligible families are subject to an enrollment fee. See more specific information regarding reasons for denial in the charts section.

Demographically, the program mirrors the population as a whole.



In the future this data will be able to be better defined as the Department of Health and Human Services is in the process of collecting race and ethnicity data separately, echoing the recent changes in the US Census Bureau race and ethnicity categories.

Provider Task Force Efforts

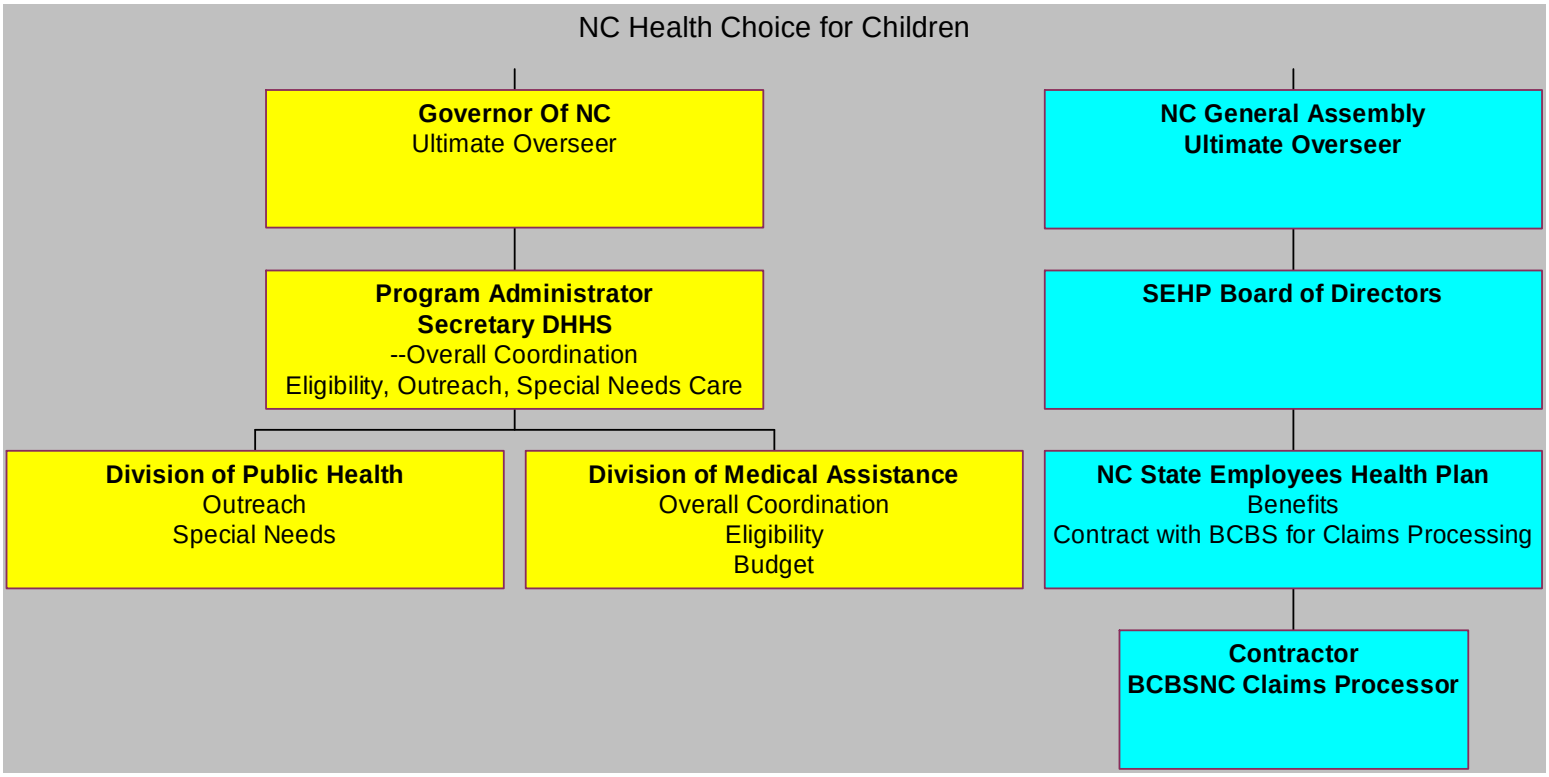
The Provider Task Force is an ongoing ad hoc group of representatives of provider organizations including hospitals, physicians, dental, vision, hearing, rural clinics, major medical centers, etc. Headed up by the NC Pediatric Society and the NC Family Care Association, the Provider Task Force maintains an ongoing policy link between the provider community and the program. Now taking on the role of a quality oversight body, the Provider Task Force examines benefits and advises program representatives on appropriate coverage decisions. The Task Force has been involved significantly in outreach efforts, particularly to families whose certification period is expiring and who need to reenroll.

Commission on Children with Special Health Care Needs

The North Carolina Commission on Children with Special Health Care Needs is a legislated body that provides guidance to the NC Health Choice Program for Children, related to the issues affecting children with special needs.

The Commission was established in the original NC Health Choice legislation. The members, appointed by the Governor, closely monitor such things as the progress and actual results of the state mental health reform plan implementation. They are charged with examining all arenas of health needs of special needs children whether they are NC Health Choice eligible or not. As a result they have heard reports and offered guidance on reorganization of early childhood screening programs, public school responses to children with special health care needs. Specifically, they serve as watchdogs for special needs children served by public programs.

Organizational structure



NC Health Choice is administered by several different parts of State Government. Designed by the NC General Assembly in GS 108A-70.19, the overall administration of the program (including overall policy, outreach and special needs policy) rests within the Department of Health and Human Services. The Benefits Administration is the responsibility of the Teachers and State Employees Comprehensive Major Medical Plan under the auspices of the North Carolina General Assembly.

Eligibility is determined in each of the 100 county Departments of Social Services. County eligibility workers assess family income, insurance status and other qualifications and determine who is eligible for the program. Unlike Medicaid, there is no direct county financial participation in the program. Administrative dollars to assist these counties is provided both through a direct grant to counties and through the funds collected and kept by the counties as enrollment fees. Most counties also expend additional county funds to draw down federal match for administrative costs.

NC's program has contributed to SCHIP programs nationwide.

1. Our community-center social marketing base outreach methods are now being adopted across the country.
2. Our RWJ grantees' development of idea incubators has now become the standard for the other RWJ grantees across the country.
3. Our Provider Task Force efforts involving peer-to-peer recruitment of participating providers both for NC Health Choice and Medicaid has been very beneficial to the

program. CMS has commended this effort to the other states and made a training film featuring North Carolina's program.

The legislatively mandated partnership between the Department of Health and Human Services Divisions of Medical Assistance and Public Health with the State Employees Health Plan that is NC Health Choice for Children has had some unexpected beneficial results for all programs. One of the first goals the programs had to meet was to make the programs as seamless as possible so that they could be jointly marketed. This required a careful inventory of both the Medicaid and the State Employees children's program. Because the largest gap in services between the two programs was in the area of Behavioral Health, the Commission for Children with Special Health Care Needs became involved and created the Behavioral Health Task Force which then became instrumental in examining children's mental health services. A new mental health code was created permitting a "mental health check up" with no labeling of children. The early discovery of the number of speech therapy cases being pushed into special needs funding mechanisms led the State Employees Health Plan to reexamine and repair the speech therapy benefit offered to the children of state employees and teachers. The simplification of the application process for NC Health Choice simplified the process for Medicaid children and the seamless approach led to a 12-month continuous enrollment regardless of changes in income for Medicaid recipients as well. Dental sealants are also now available to NC Health Choice kids as they are to Medicaid kids.

Generally conceded by most national policy experts to be one of the leading programs in the country, NC Health Choice's health benefit is rich, and its citizen involvement is exemplary. NC Health Choice has taken a win-win approach to its system that has worked to the benefit of all involved.

The information in the remainder of this document is designed to provide data as specified in GS 108A-70.27.

The number of applicants for coverage provided under the program. The number of program applicants deemed eligible for Medicaid.

The total number of children enrolled in Medicaid through the Program application process.

Note: There is one application form for health insurance for children. Children are assessed based on family income for both Medicaid and NC Health Choice. The outreach focus is to stress that the individual is filling out an application for health insurance under Health Check/NC Health Choice, rather than emphasizing the programmatic funding sources (Medicaid or SCHIP), and to keep the programs as seamless as possible.

The data in answer to these two questions reflects the total number of children on applications taken from October 1, 1998, to July 1, 2004.

	Health Choice	**MIC**	**Other Title XIX**	**Total**
Total Number of Children on Apps Taken	**554,118**	**667,465**	**726,548**	**1,938,131**
Total Number of Children on Approved Apps	**371,093**	**481,694**	**191,951**	**1,044,738**
Total Number of Children Denied/ Withdrawn	**172,877**	**174,798**	**452,872**	**800,547**

The number of applicants deemed eligible for the program by income level, age, and family size.

The following table represents demographic data for the month of July 2004. The point-in-time field is the most accurate way to present this information. Please note the columns are not cumulative.

Family size	Male	Female	Asian	Hispanic	Other	Black	Indian	White	100-150% fpl	151-200% fpl
FAMILY OF 1										
AGE<1										
AGE 1-5										
AGE 6-12	3	1				1		3	3	1
AGE 13-18	7	18			2			17	25	

FAMILY OF 2										
AGE <1	9	4		1	1	4		7	7	6
AGE 1-5	169	159	3	7	47	137	2	132	159	169
AGE 6-12	204	192	3	1	20	169	7	196	365	91
AGE 13-18	147	183	2	1	22	156	8	141	245	85
FAMILY OF 3										
AGE<1	43	30	1	5	27	9		31	41	32
AGE 1-5	314	296	1	27	184	108	10	280	268	342
AGE 6-12	400	441	9	11	84	355	20	362	660	181
AGE 13-18	282	289	6	5	34	247	25	254	429	142
FAMILY OF 4										
AGE<1	17	18		2	2	3		21	12	23
AGE 1-5	246	266	6	18	142	76	1	259	251	261
AGE 6-12	375	391	8	17	132	199	21	389	587	179
AGE 13-18	180	159	3	1	27	127	11	170	277	62
FAMILY OF 5										
AGE <1	3	9			1	2	2	7	8	4
AGE 1-5	117	108	2	30	5	62	1	127	116	109
AGE 6-12	232	243	6	16	109	101	12	231	374	101
AGE 13-18	98	90	3	2	29	58	3	93	137	51
FAMILY OF 6										
AGE<1	1							1		1
AGE 1-5	32	27	4	4	20	5	1	25	26	33
AGE 6-12	74	79	7	2	32	34	10	68	127	26
AGE 6-18	31	35			10	15	1	40	60	6
FAMILY OF 7										
AGE <1	1					1				1
AGE 1-5	3	7	1		6			3	8	2
AGE 6-	26	19	2	1	12	23		7	40	5

12										
AGE 13-18	11	17	2	3	11	9		3	26	2
FAMILY OF 8										
AGE <1										
AGE 1-5		3	1		1			1	1	2
AGE 6-12	9	8	5		3	5		4	15	2
AGE 13-18	4	2	1			1		4	3	3
FAMILY OF 9										
AGE <1										
AGE 1-5		1	1						1	
AGE 6-12	6	6	3			4		5	12	
AGE 13-18	13	3	3			8		5	16	
ALL										
AGE<1	74	61	1	8	38	19	2	67	68	67
AGE 1-5	881	867	18	62	462	356	25	825	830	918
AGE 6-12	1331	1386	51	48	392	891	70	1265	2131	586
AGE 13-18	777	800	28	12	135	627	48	727	1226	351

The number of applications made at county departments of Social Services, public health departments and by mail.

	Medicaid	**NC Health Choice**
Health Departments	1,428	292
County DSS	153,531	35,597
Mail	53,074	24,603
Total	208,033	60,492

The number of applicants deemed ineligible for the Program and the basis of ineligibility.

Reasons for denial of applications for NC Health Choice during state fiscal year 2004 by source

County Departments of Social Services

Has health insurance or Medicare	*1099*
Enrollment fee	*1339*
Income exceeds poverty level	*1382*
State Residency	*1*
Non Citizen/Refugee/Qualified Alien	*25*
Receiving Assistance in another case	*78*
Approved for other aid program	*61*
Needed information not provided	*754*
Moved to another state	*4*
Unable to Document Alien Status	*2*
Administrative error	*2953*
Reason Unknown	*23*
Total for County DSS offices	*7732*

CountyHealth Department

Needed Information Not Provided	*11*
Moved to Another State	*18*
Unable to Document Alien Status	*50*
Administrative Error	*50*
Reason Unknown	*15*
Total for County DPH offices	*101*

Mailed

Has health insurance or Medicare	*850*
Enrollment Fee	*894*
Income Exceeds Poverty Level	*1925*
Receiving Assistance in Another Case	*139*
Approved for Other Aid Program	*33*
Needed information not provided	*730*
Administrative Error	*2067*
Total Denied of Mailed Apps	*6717*

Overall Denied Apps *14,550*

Withdrawn Apps

Withdrawn Apps County DSS	*36*
Withdrawn Apps Health Departments	*0*
Withdrawn Apps Mailed	*13*
Total Withdrawn Apps	*49*

Summary: After various administrative errors (all signed application forms must be accounted for, therefore many "errors" are very minor. For example, if a parent made several mistakes and cross-outs in one form and wanted to have a "fresher" copy, the first version would be counted in the "administrative error" column); the number one reason for application denial is that the family "income exceeds the poverty level" (200% federal poverty level); second, is that the family "failed to pay the enrollment fee" ($50 for one child; $100 for two or more children only for families over 150% of the federal poverty level or 20% of the members served); and third, is "has insurance or Medicare."

The total number of children newly enrolled to date and for the immediately preceding year.

The total number enrolled between July 2003 and June 2004 were:

Health Departments	292
Departments of Social Services	35,597
Mailed applications	24,603
Total	*60,492*

Trends showing the Program's impact on hospital utilization, immunization rates, and other indicators of quality of care, cost-effectiveness and efficiency.

Efforts have been underway through outreach and through an asthma pilot program to see if improper usage of the emergency room could be reduced. Hospital admission rates have continued to show a slight decline as have emergency room visits which dropped to 344.2 visits per 1,000 members. Most of this decrease occurred among the below 150% of federal poverty level population. Immunization rates remain among the top six in the country.

Trends related to the health status of children.

Well-child visits are increasing for all sectors of the population. Even among special needs children, well child visits rank among the top codes. The number of children who qualify for the special needs wrap around services compared to the overall population has remained fairly stable at 5%. Most of the diagnoses in the special needs wrap around are related to behavioral health.

The NC Child Advocacy Council's Child Health 2003 Report Card credits the state's overall 3% increase in immunization rate by the second birthday to when NC Health Choice began in 1998.. School age immunization improvement increased over the same time period from 98.3 percent to 99.6 percent. It is only a one percent increase, but the state is very close to 100% immunizations by school age. In the area of dental caries prevention, the Child report card shows an increase of the percentage of children with sealants having increased 32% in the same time period. NC Health Choice added sealants to its benefits in 1999.

Selected HEDIS measures for NC Health Choice are as follows:

1. Well child visits for the first 15 months of life.
Rates are for eligibility and claims data for calendar year 2003.

Denominator - 32
Numerator –
Seven separate numerators are calculated, corresponding to the number of members who received zero, one, two, three, four, five, and six or more well child visits with a primary care practitioner during their first 15 months of life:

Zero	3
One	0
Two	1
Three	1
Four	8
Five	12
Six or more	7
	32

Rates –

Zero	9.38%
One	0.00%
Two	3.13%
Three	3.13%
Four	25.00%
Five	37.50%
Six or more	21.88%
	100.02%

2. Well child visits for the 3rd, 4th and 6th years:
Definition of Population Included in Measure:
Ages – Three, four, five or six years old as of December 31 of 2003.

Continuous Enrollment – Continuously enrolled during 2003.

Allowable gap – NC Medicaid verifies enrollment monthly. Member may not have more than a 1-month gap in coverage to be included in this measure.

Anchor Date – Enrolled as of December 31 of 2003.

Delivery System of Care – Medicaid (HealthChoice).

Baseline / Year:
NC HealthChoice submitted data for this measure for 2002 claims data (submitted end-of-year 2003). The data submitted will serve as baseline.

2002 rate –

Numerator	3,814	=	55.50%
Denominator	6,872		

3. Children's Access to Primary Care Practitioners

Performance Progress/Year:
In this report, NC HealthChoice submits data for this measure for 2003 claims data.

2003 rate –

Numerator	5,417	=	54.82%
Denominator	9,881		

Zero	9.38%
One	0.00%
Two	3.13%
Three	3.13%
Four	25.00%
Five	37.50%
Six or more	21.88%
	100.02%

Further definition of the claims selected:

Selected claims with following places-of-service
OUTPATIENT DEPT
OFFICE
PATIENT'S HOME
OTHER

Specifically excluded the following CPT codes regardless of the diagnosis codes :	
ANESTHESIA	HA112
EMERGENCY DEPT VISIT	99281
EMERGENCY DEPT VISIT	99282
EMERGENCY DEPT VISIT	99283
EMERGENCY DEPT VISIT	99284
EMERGENCY DEPT VISIT	99285
DIRECT ADVANCED LIFE SUPPORT	99288

Only allowed the following billing provider specialty codes when determining well child visits :	
GP-GENERAL PRACTICE	012
I-INTERNAL MEDICINE	015
PEDIATRICS	030
PH-PUBLIC HEALTH	031
FP-FAMILY PRACTICE	041
MSP-MULTISPEC OR PDC	100
I-INTERNAL MED GROUP	115
PD-PEDIATRICS GROUP	130
INTERNAL MEDICINE	188
FAMILY NURSE PRACTITIONER	190

An analysis of all of the above with trends and projections for continued program funding.

NC Health Choice for Children is accomplishing its mission. According to several surveys of families conducted by researchers at the University of North Carolina and the University of North Carolina at Charlotte, NC Health Choice is a very popular program among its members, the program provides well-child and sick care visits, dental, pharmacy and behavioral health care.

For the past year the population growth has held steady at 1 percent a month. Costs to the program have tracked the inflationary rate of health care for the state and nation. Closer monitoring of behavioral health services have held costs to a relatively constant level in the special needs area.

NC Health Choice draws down available federal funds to the maximum state appropriations will allow. There continues a constant effort to use allocated dollars to maximize health insurance to children and to minimize administrative costs. Although the federal cap on administrative costs is as high as 10% of the overall allocation, NC Health Choice has held its administrative overhead to less than 5 percent since the initial start up costs.

Nationwide, the SCHIP program is very popular with recipients, voters and elected officials including members of Congress. As previously stated, through SFY 2003, Congress made available over one billion dollars each year to assure that unused funds from other states could be reallocated rather than allowing those funds to revert to the US Treasury. It is anticipated that the program will be reauthorized with some modifications including the recognition that state legislatures need to know the funding levels for the program. Currently the reauthorization process is expected to be moved up from federal fiscal year 2007 to 2005 and to be included in the Medicaid reform debates.

Assessment of most and least effective areas.

As NC Health Choice enters its 7th year, the most effective area remains the team of local and state officials, advocates, providers and citizens who work together to make the program successful. The focus of program administration has been on smoothing rough patches rather than creating road blocks to care and it has worked. Even communications glitches between separate information systems have been resolved through the committed work of both the public agencies and Blue Cross Blue Shield. The least effective area in the program has been the fact that it has thus far proven difficult to impossible to impose case management on an any willing provider indemnity program. Efforts continue to design a method of assuring cost control while continuing physician/patient care control. The program is comparable in health quality and benefits to the two entities it was created from – North Carolina's Medicaid program and the State Employees Health Plan. Surveys have repeatedly underscored its popularity among recipients and there are many providers who accept NC Health Choice even as they decline to accept Medicaid and the State Employees Health Plan. As a health insurance product, its benefits combine the best of both Medicaid and the State Employees Health Plan. As a program to provide health care to the children of working people of North Carolina, NC Health Choice works.